

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4180

04174

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #1 Box 72</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u> d. STREET ADDRESS <u>R.F.D. #1 Box 72</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lulu M. Boddy</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1961</u>		5. SEX <u>Female</u>			
6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2, 1873</u>			
9. AGE (In years last birthday) <u>88 yrs.</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u></u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Conowingo, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John H. Bradford</u>					
14. MOTHER'S MAIDEN NAME <u>Josephine Berry</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs. Bella B. Bond, Port Deposit, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction - Fibrillation</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile - Generalized</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 wks.</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>April 3, 1961</u> Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (the hospital) attended the deceased from <u>Dec. 15, 1952</u> to <u>April 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1961</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Shepherd R. O.</u>				22b. DATE SIGNED <u>4/6/61</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 9, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Methodist Cem.</u>			
23d. LOCATION (City, town or county) <u>Conowingo, Cecil, Md.</u>		(State)		25a. REC'D BY REGISTRAR <u>APR 10 '61</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock, Starve de Grace, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoma</u>			

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page _____ be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
CERTIFICATE OF DEATH									
Items 8 & 9, birth cert. in this division for Edward Briscoe-4/21/61									
1. PLACE OF DEATH a. COUNTY CECIL MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON					c. LENGTH OF STAY IN 1b 9 DAYS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First EDWARD Middle R Last BRISCOE			4. DATE OF DEATH Month 4 Day 12 Year 1961						
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1915 9-12-1915	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months 5 Days 8 Hours Min. 		IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME HARRY BRISCOE					14. MOTHER'S MAIDEN NAME SALLY YOUNG				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 217-26-6681		INFORMANT Harry Briscoe North East Ind Address 				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Convulsion DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Parenchymatous Nephritis DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH 9 Days 2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4/3/1961 to 4/12/1961 , that I last saw the deceased alive on 4/12/1961 , and that death occurred on 4/12/1961 at 10:35 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE James L. Johnson					ADDRESS (Street, city or town, state) 245 East High Street DATE SIGNED 4/14/61				
PHYSICIAN'S NAME (Type) James L. Johnson M. D.					Elkton Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-1961		22c. NAME OF CEMETERY OR CREMATORY St Marks C. U. M. P.		22d. LOCATION (City, town, or county) (State) North East Cecil Co Ind			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant North East Ind					24a. REC'D BY REGISTRAR DATE 4-17-61		24b. REGISTRAR'S SIGNATURE Arthur L. Krause		

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Briscoe-4/21/61
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04176

4182

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 wk.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET Elizabeth Bryson		4. DATE OF DEATH Month 4 Day 18 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1905
9. AGE (In years last birthday) yrs. 55		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clement Reeder		14. MOTHER'S MAIDEN NAME Mary Rice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Charles E. Bryson, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal CARCINOMATOSIS 172X DUE TO CARCINOMA, CORPUS UTERI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/14, 1961, to 4/18, 1961, that I last saw the deceased alive on 4/18, 1961, and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Fischer M.D.		ADDRESS (Street, city or town, state) 162 W MAIN ST. ELKTON, MD	
PHYSICIAN'S NAME (Type) John A Fischer		DATE SIGNED 4/19/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/22/61	22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cemetery, North East, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		24a. REC'D BY REGISTRAR DATE APR 25 1961	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
4183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04177														
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Graybeal N. Hone, Nottingham</u>					c. LENGTH OF STAY IN 1b <u>4 yrs.</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Graybeal N. Hone, Nottingham</u>					e. STREET ADDRESS <u>Rising Sun Main St.</u>									
3. NAME OF DECEASED (Type or print) <u>Mary Wobthington Cherry</u>					4. DATE OF DEATH <u>4</u> <u>15</u> <u>19 61</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-4-1873</u>		9. AGE (In years last birthday) <u>87</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME <u>Edward H. Worthington</u>					14. MOTHER'S MAIDEN NAME <u>Emiline Miller</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <u>none</u>					17. INFORMANT <u>William Cherry, Rising Sun, Md.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis and Extreme Arterio Sclerosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (e), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) _____ (County) _____ (State) _____					21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>4/18/1961</u>					22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>				
22d. LOCATION (City, town, or country) <u>Colona</u>					22e. (State) <u>Md.</u>					23. FUNERAL DIRECTOR <u>Edmon E. McMillan</u> ADDRESS <u>Rising Sun, Md.</u>				
24a. REC'D BY REGISTRAR <u>APR 18 '61</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>					24c. DEPUTY MEDICAL EXAMINER <u>Rising Sun, Md.</u> ADDRESS <u>4-16-61</u>				

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EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Item 23b, Film 6285 4/18/61 ink

04178

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, c. LENGTH OF STAY IN 1b 51 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VAH., Perry Point, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon d. STREET ADDRESS 12X-2	
3. NAME OF DECEASED (Type or print) Chester L. COGSWELL		4. DATE OF DEATH Month April Day 9 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/08
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor		10b. KIND OF BUSINESS OR INDUSTRY Electrical	
11. BIRTHPLACE (County & State, or foreign country) Terre Haute, Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Cogswell		14. MOTHER'S MAIDEN NAME Mae Boyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 219-10-9287	
17. INFORMANT Hospital records. Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia - Right Lung Unresolved 162-1 Conditions, if any, which gave rise to immediate cause (b) Carcinoma, Bronchogenic - Right-lung (c) Unknown DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/17/61 to 4/9/61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/9/61 and that death occurred at 10:25 PM from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney		22b. DATE SIGNED 4/10/61	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, M.D. Pathologist		22d. ADDRESS VAH., Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/12/61	
23c. NAME OF CEMETERY OR CREMATORY Bethel Presbyterian		23d. LOCATION (City, town or county) (State) Harford County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE JENNINGS & SON, Havre DeGrace, Md.		25. REC'D BY REGISTRAR APR 13 '61	
25a. REGISTRAR'S SIGNATURE Charles L. Thomas		25b. REGISTRAR'S SIGNATURE	

57820

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CERTIFICATE OF DEATH

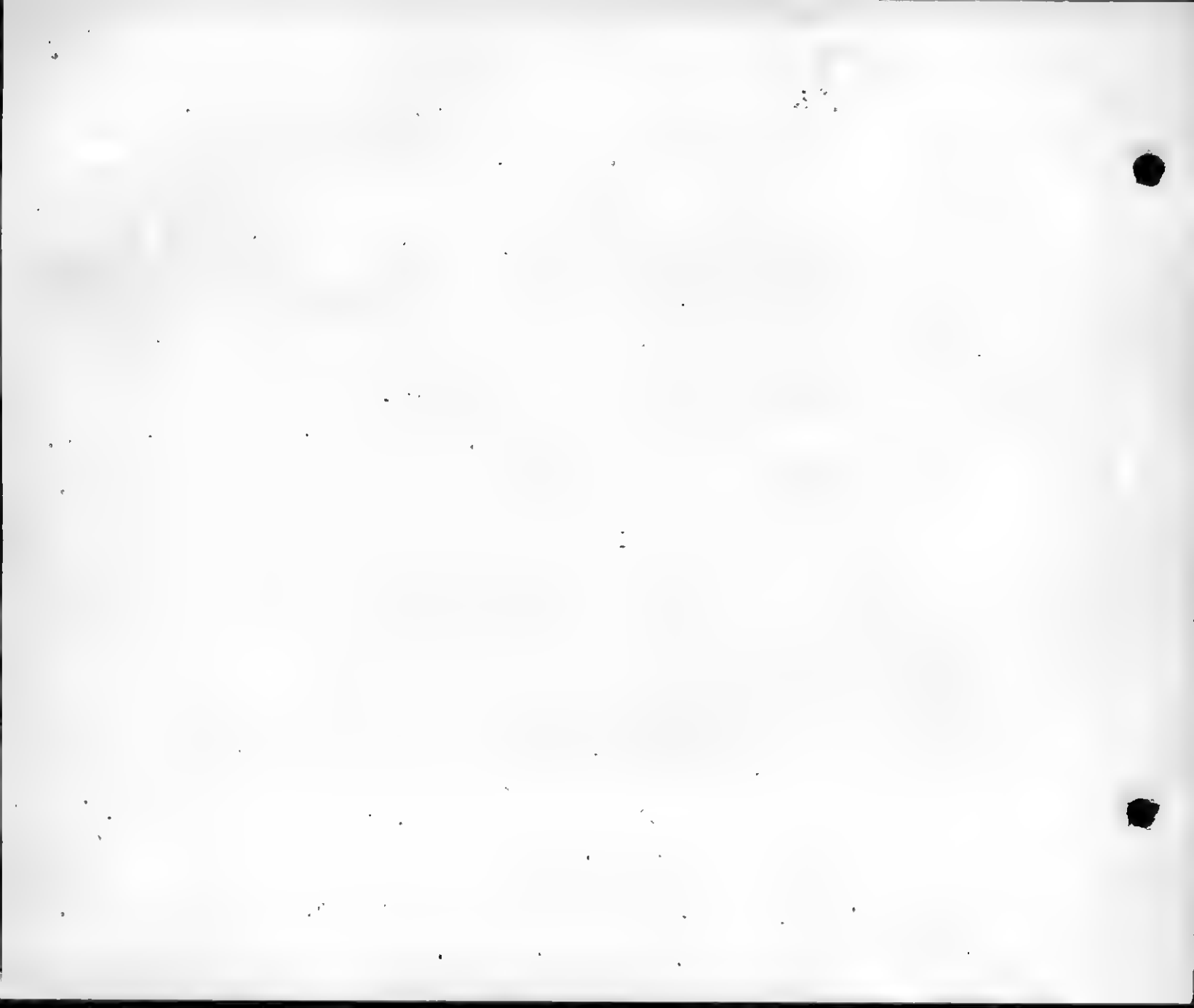
Reg. Dist. No. 04179

4185

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
c. LENGTH OF STAY IN lb 4 Yrs.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Oliver Henry COLLINS		4. DATE OF DEATH Month April Day 17 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 30, 1874
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Jewelry	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Wesley Collins		14. MOTHER'S MAIDEN NAME Mary Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Lewis A. Collins Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malnutrition 5 DUE TO (b) Starvation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959, to April 17, 1961, that I last saw the deceased alive on April 16, 1961, and that death occurred at 10:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry Davis M.D.		ADDRESS (Street, city or town, state) Chesapeake City, Md. DATE SIGNED 4/17/61	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD			
22a. BURIAL, CREMAT., ON, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/19/61	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Hr. Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME, 1211 N. Elkton, Md.		24a. REC'D BY REGISTRAR DATE APR 20 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director, and completely filled in by the funeral director. Then please remove carbon permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



CERTIFICATE OF DEATH

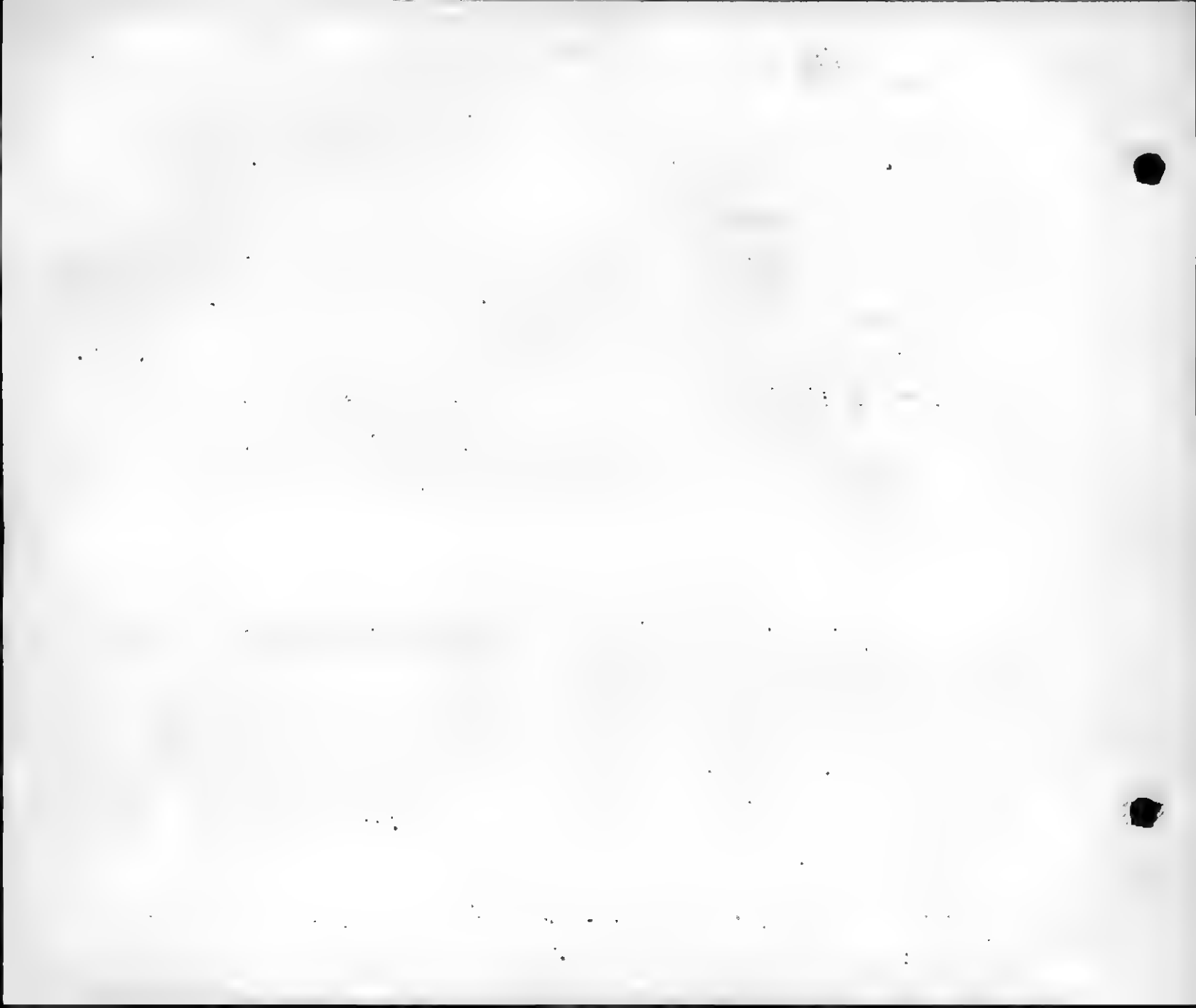
Reg. Dist. No.

04180

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>NORTH EAST RD 1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE FAKE COOK</u>		4. DATE OF DEATH Month Day Year <u>4 - 14 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-61</u>
9. AGE (In years last birthday) <u>-</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>- 35</u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ESTEL H. COOK</u>		14. MOTHER'S MAIDEN NAME <u>DOROTHY BARTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Estel H. Cook North East Rd 1 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mongolian Idiocy</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital Heart Disease - type undetermined</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>- 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/10</u> , 19 <u>61</u> , to <u>4/13</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11 April</u> , 19 <u>61</u> , and that death occurred at <u>2 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Klaus H. Huebner</u> M.D.		ADDRESS (Street, city or town, state) <u>North East Rd</u> DATE SIGNED <u>4/13/61</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-15-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>North East Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>North East Cecil Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Grant</u>		24a. REC'D BY REGISTRAR <u>North East Md</u> DATE <u>APR 17 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the following information: Name of the deceased, date and place of birth, date and place of death, cause of death, and other information as required by the law. The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the following information: Name of the deceased, date and place of birth, date and place of death, cause of death, and other information as required by the law.

VR A15 (4)
15M 9/59

4187

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04181

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Craigtown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Bruce Last Craig		4. DATE OF DEATH Month April Day 14 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1876
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months 84 Days 14 Hours 19 Min 61	11. IF UNDER 24 HRS Hours 19 Min 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Gen. Building	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert B. Craig		14. MOTHER'S MAIDEN NAME Leah A. Patterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 214-01-7956	
17. INFORMANT Jane B. Craig, Port Deposit, Md. Rural		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crown an occlusion DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 1961 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 1961	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/11 , 19 61 , to 4/14 , 19 61 , that (I) (we) last saw the deceased alive on 4/12 , 19 61 , and that death occurred at 1200 AM, from the causes and on the date stated above			
22a. SIGNATURE Irvin Wachsmann, M.D.		22b. ADDRESS Havre De Grace, Md.	
22c. PHYSICIAN'S NAME (Type) Irvin Wachsmann, M.D.		22d. ADDRESS Havre De Grace, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 4-16-1961	
23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Leah A. Patterson		25a. REC'D BY REGISTRAR Perryville, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. DATE APR 18 '61	



4188

CERTIFICATE OF DEATH

Reg. Dist. No.

04182

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark, Del. R.D. "2"		c. LENGTH OF STAY IN 1b 5yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark, Del. R.D. 2	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Rulon Dare		4. DATE OF DEATH Month Day Year April 22 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Engr.		10b. KIND OF BUSINESS OR INDUSTRY Paint Manufact.	
11. BIRTHPLACE (State or foreign country) N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Job Rulon Dare		14. MOTHER'S MAIDEN NAME May Mulford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 152 09 0262	
17. INFORMANT Address Mrs. C.R. Dare Newark, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma Pleura & Brain 1 year DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anaplastic Carcinoma Site undeterm 1+ yrs DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1959, to 4-22, 1961, that I last saw the deceased alive on 4-20, 1961, and that death occurred at 9:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Williford Eppes M.D. 327 E Main St Newark Del 4-23-61			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/25/61	22c. NAME OF CEMETERY OR CREMATORY Friends Cem.	22d. LOCATION (City, town, or county) (State) Greenwich N.J.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE APR 28 '61	24b. REGISTRAR'S SIGNATURE

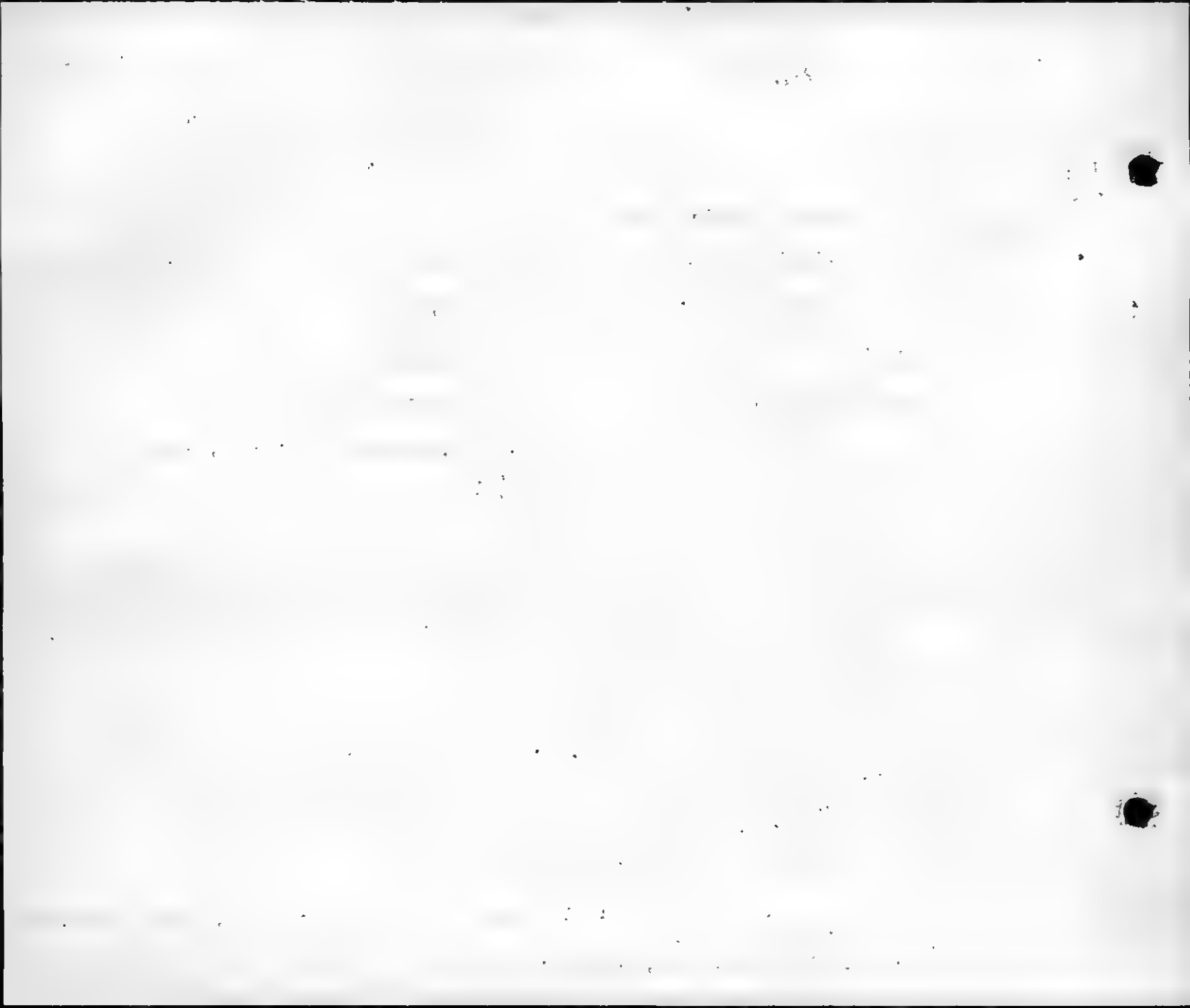
MEDICAL CERTIFICATION

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



M

VS AIS (4)
ISM 9/5B



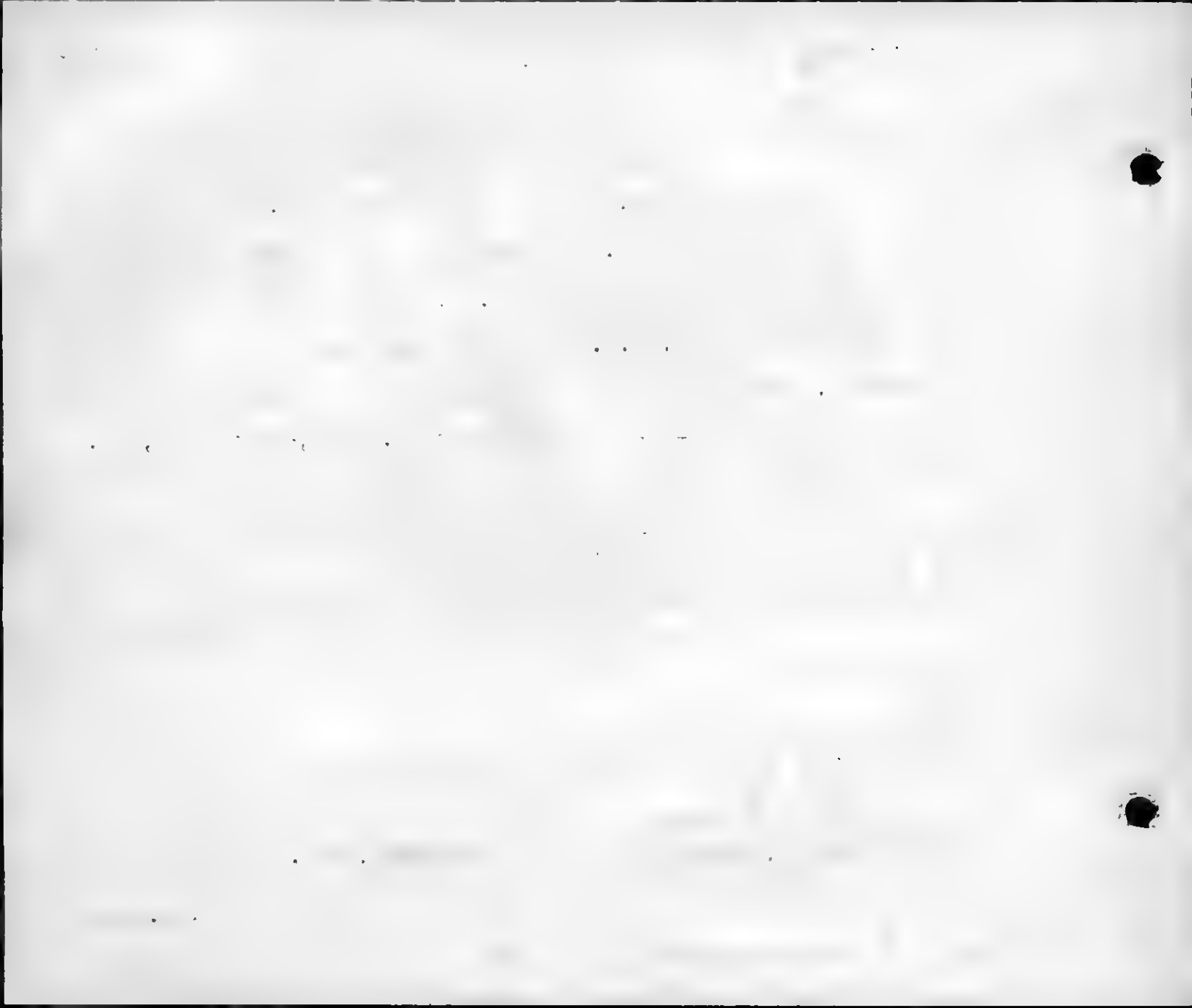
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4190

04184

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville			c. LENGTH OF STAY IN 1b 42 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perryville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Susquehanna Ave.				d. STREET ADDRESS 1 Susquehanna Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oscar Middle R. Last Evans				4. DATE OF DEATH Month April Day 10 Year 1961			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 20, 1889		9 AGE (In years lost birthday) 71 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trainman		10b. KIND OF BUSINESS OR INDUSTRY Pa. R.R.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter G. Evans				14 MOTHER'S MAIDEN NAME Maggie Conard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16 SOCIAL SECURITY NO 716-01-7872		17 INFORMANT Elizabeth E. Evans, Perryville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism, massive DUE TO (b) Phlebotrombosis, lower extremities DUE TO (c) Bronchogenic carcinoma, right lung						INTERVAL BETWEEN ONSET AND DEATH Terminal 2 weeks 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1-19-1961 to 4-10-1961 , that (I) (we) last saw the deceased alive on 4-9-1961 , and that death occurred on 4-10-1961 from the causes and on the date stated above.							
22a SIGNATURE Peter P. Redman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 4-11-61	
22c PHYSICIAN'S NAME (Type) Peter P. Redman				22d ADDRESS Aberdeen, Md.			
23a BURIAL, CREMATON, or other disposition (Specify) Burial		23b DATE THEREOF 4-13-1961		23c NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
24 FUNERAL DIRECTOR'S SIGNATURE See a. Patterson & Son, Perryville, Md.				25a REC'D BY REGISTRAR DATE APR 14 '61		25b REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 04185

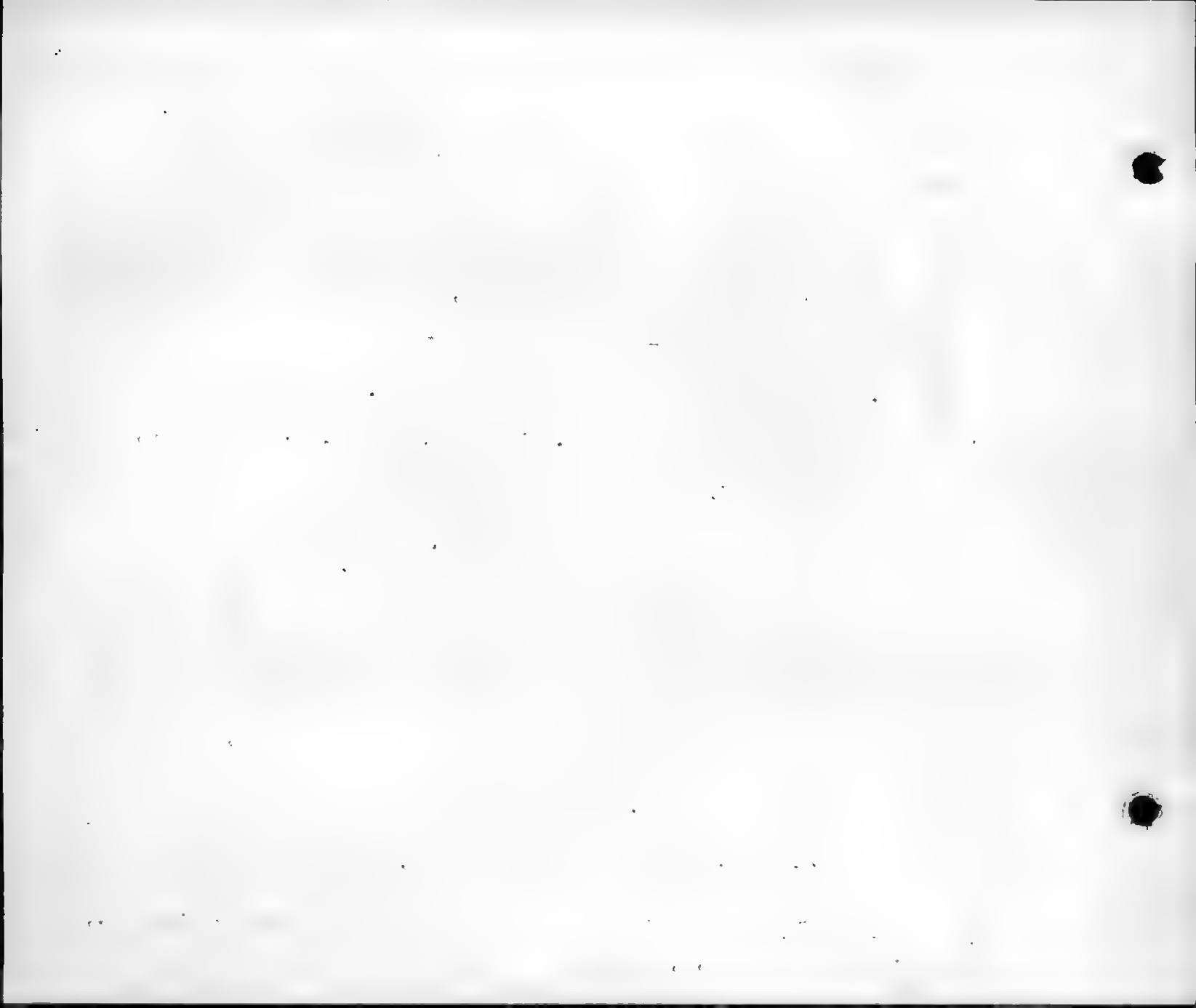
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rhoda Middle A Last Ferguson		4. DATE OF DEATH Month 4 Day 28 Year 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1880
9. AGE (In years lost birthday) yrs. 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Armour		14. MOTHER'S MAIDEN NAME Mary E. Brickley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. W. Atlee	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO nephrosclerosis with anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) nephrosclerosis, generalized (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-16-1961, to 4-28-1961, that I last saw the deceased alive on 4-27-1961, and that death occurred at 4-28-1961 from the causes and on the date stated above.			
ACTUAL SIGNATURE Tullian D. Johnson M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1235 N. 5th Ave 4-28-61	
PHYSICIAN'S NAME (Type) Tullian D. Johnson		Elkton, Md	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-1961	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist		22d. LOCATION (City, town, or county) (State) Rising Sun Rd. Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR DATE MAY 2 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

1

Page 4

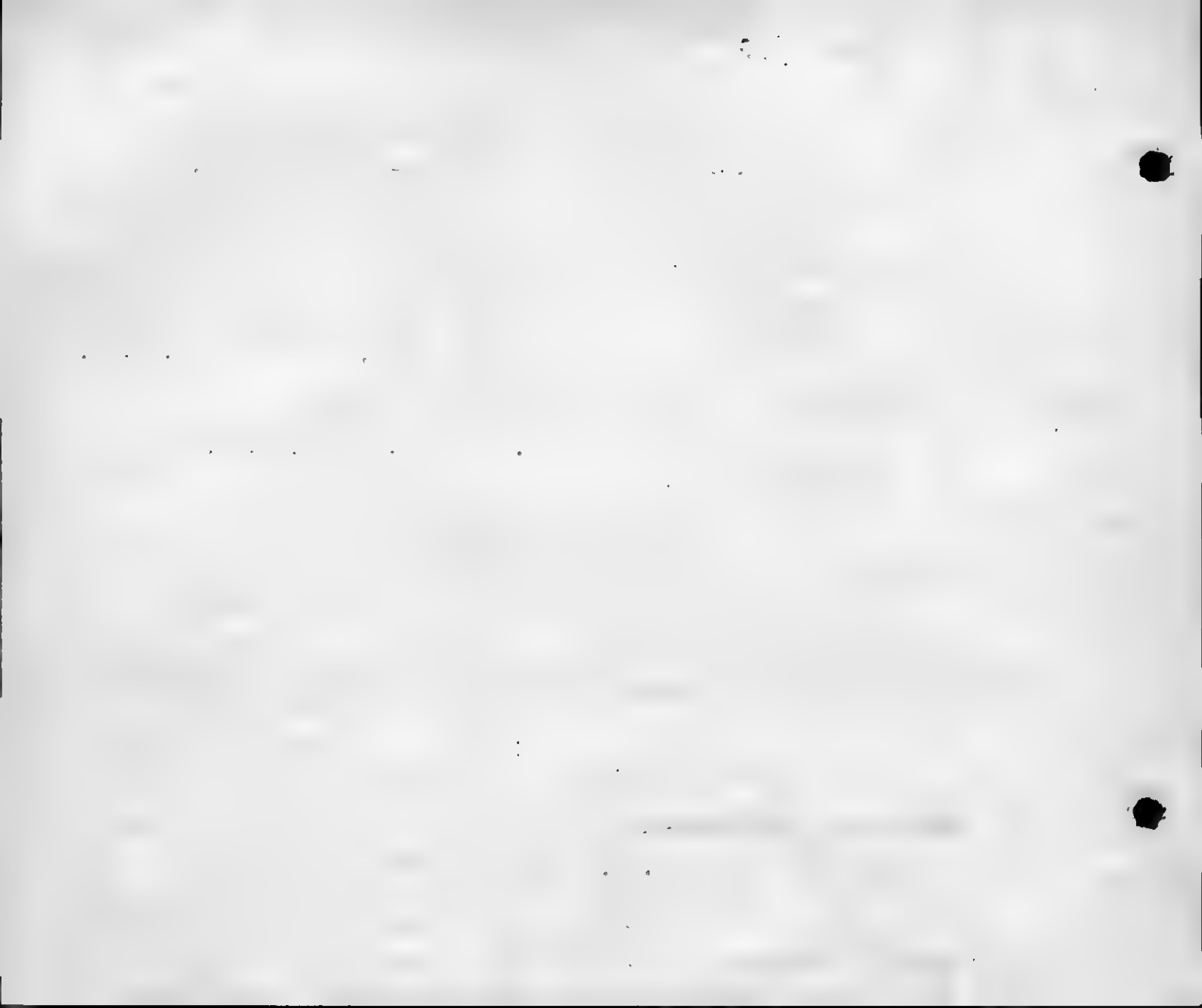
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Arthur S. Kraus

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

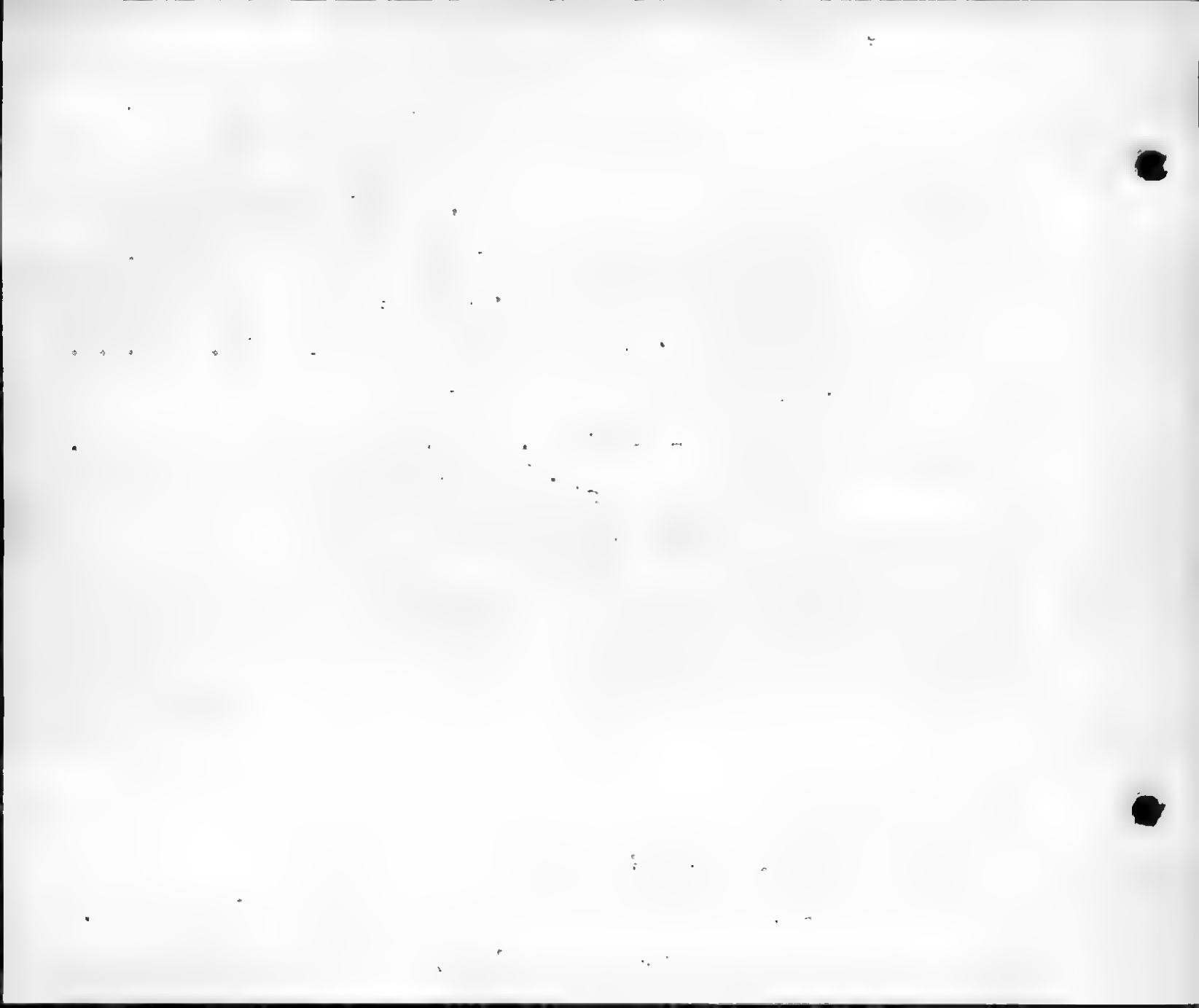
4193

CERTIFICATE OF DEATH

Reg. Dist. No. 04186

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL HOPKINS		4. DATE OF DEATH Month Day Year April 4, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1893
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL	
11. BIRTHPLACE (State or foreign country) Principio Furnace, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hopkins		14. MOTHER'S MAIDEN NAME Fannie Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-30-037	
17. INFORMANT Mrs. Elizabeth Reynolds, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebro Vascular Accident (b) Hypertension (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 days 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/29, 1961, to 4/4, 1961, that I last saw the deceased alive on 4/4, 1961, and that death occurred at 7 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph G. Lanzi, M.D.		ADDRESS (Street, city or town, state) 205 W Main St - Elkton Md	
PHYSICIAN'S NAME (Type) Joseph G. Lanzi, M.D.		DATE SIGNED 4/6/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-61	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME 101 N. 1st St. Elkton, Md.		24a. REC'D BY REGISTRAR DATE APR 10 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director, who may be retained by the hospital or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04187

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS Box Booth St. Rx. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Howard First Middle Last		4. DATE OF DEATH Month 4 Day 22 Year 1961	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1907 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		11. BIRTHPLACE (State or foreign country) Morrisville, N.C.	
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-12-9180	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation of Aorta Internal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 981X		17. INFORMANT Bernard R. Howard, Elkton, Md. Address Interval BETWEEN ONSET AND DEATH Inst.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was shot by a 38 Caliber Revolver	
20c. TIME OF INJURY Month, Day, Year 2. 4. 1961	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tavern	20f. (City or town) (County) (State) Elkton Cecil Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Rising Sun, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-61	
22c. NAME OF CEMETERY OR CREMATORY Berkley Cemetery		22d. LOCATION (City, town, or country) (State) Darlington, Maryland	
23. FUNERAL DIRECTOR Atkins J. Bullock, State de Grace, Md.		24a. REC'D BY REGISTRAR May 1 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION



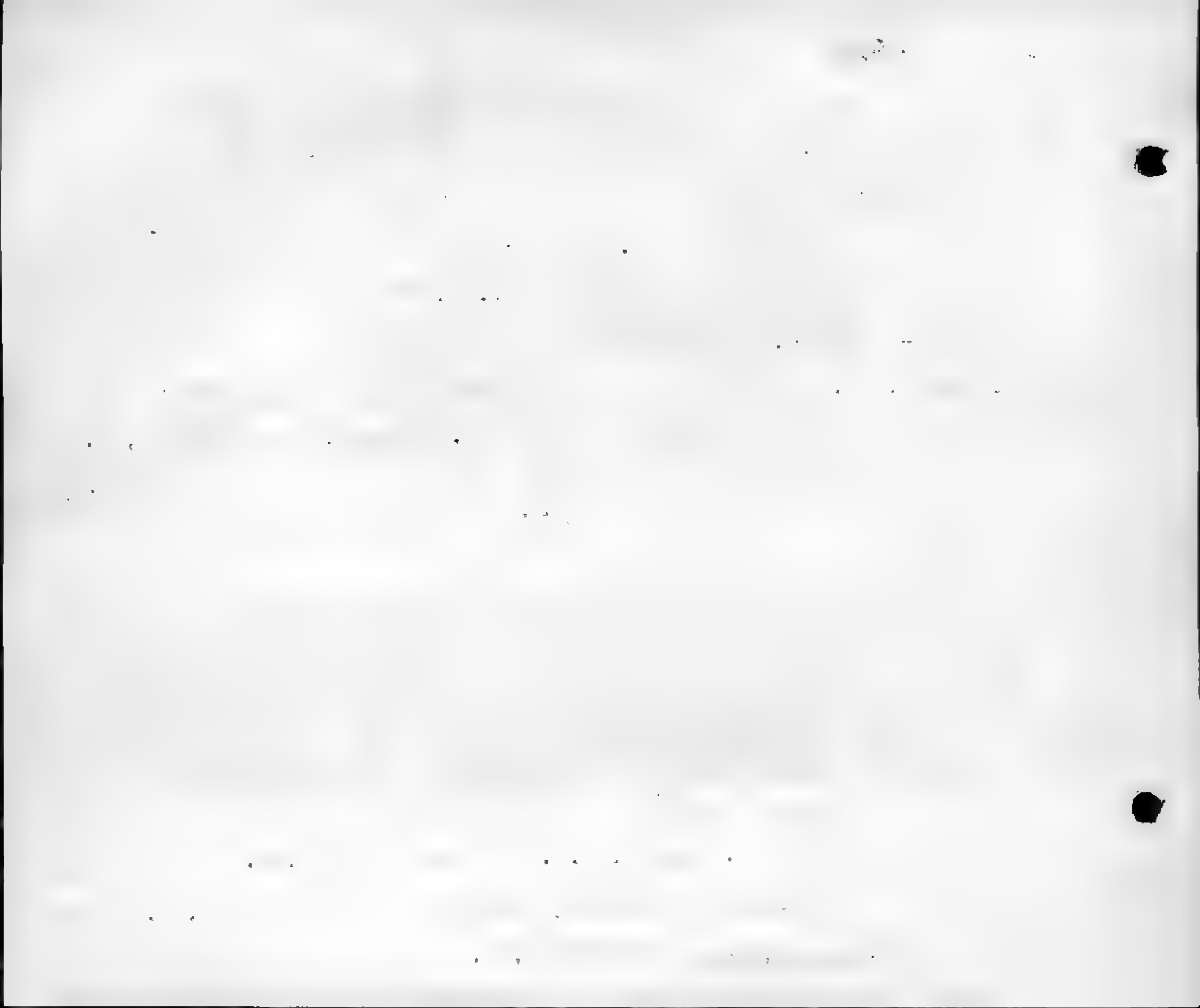


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4195

04168

1. PLACE OF DEATH o. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write full name of place) Port Deposit, Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Mills				d. STREET ADDRESS Jacksons Mills		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rufus		First G.		Middle Jackson		Last	
4. DATE OF DEATH April 20 1961		Month		Day		Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1874		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Miller Farmer,		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edward W. Jackson				14. MOTHER'S MAIDEN NAME Susannah Gillespie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rufus M. Jackson, Port Deposit, Md. R F D			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 15 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Port Deposit, Md.		20g. (County) Cecil		20h. (State) Md.
21. I certify that (I) (this hospital) attended the deceased from January 19, 1961 to April 19, 1961 ; that (I) (we) last saw the deceased alive on April 19, 1961 ; and that death occurred at 2:53 P.M. from the causes and on the date stated above							
22a. SIGNATURE Clarence I. Benson		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Apr. 20-61	
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.		22d. ADDRESS Port Deposit, Md.					
23a. BURIAL OR CREMATION, SPECIFY Burial	23b. DATE THEREOF 4-22-1961	23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City, town, or county) Port Deposit, Md. Rural		23e. (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lea Patterson & Son		ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR APR 24 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

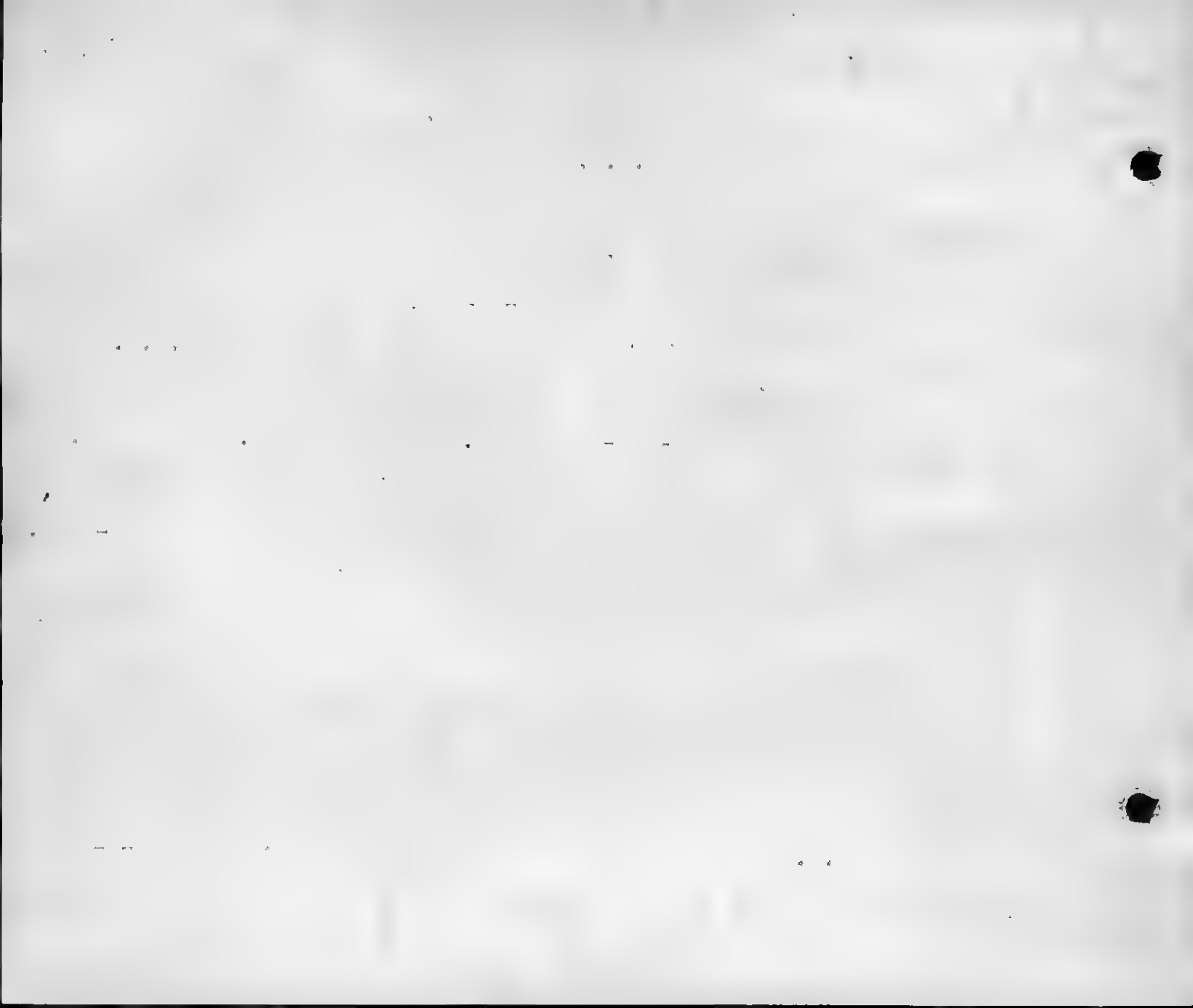
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4196

04189

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY in 1b D.O.A.		d. STREET ADDRESS 1 Route 40 and Landing Lane	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital		e. 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George T. Magiros	4. DATE OF DEATH 4 6 19 61	5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-25-1892	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturant		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Magiros		14. MOTHER'S MAIDEN NAME No information	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 218-32 -1549	
17. INFORMANT Mrs. Sophia Magiros. Elkton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis (b) Coronary Heart Disease (c) General Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 min. 3-5yrs. 10 years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-7-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 10, 1961	
22c. NAME OF CEMETERY OR CREMATORY GREEK ORTHODOX		22d. LOCATION (City, town, or country) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME 1001 N. 1st St. ELKTON, MD.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Charles S. Hanna	
DATE APR 13 '61			

MEDICAL CERTIFICATION



4197

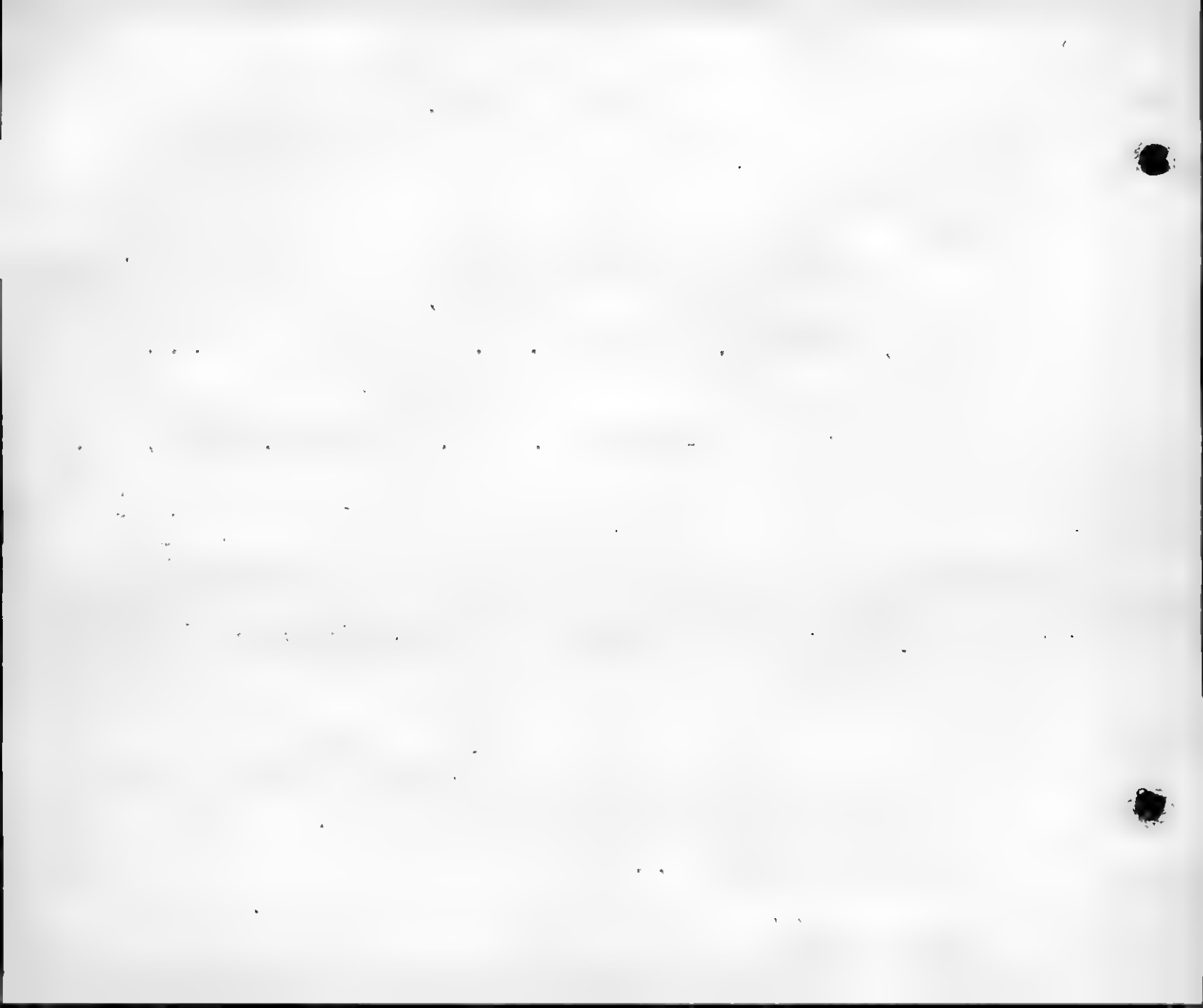
CERTIFICATE OF DEATH

Reg. Dist. No. 04190

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS X	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Boyd Last Missimer		4. DATE OF DEATH Month April Day 4 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector, Steel Pipe		10b. KIND OF BUSINESS OR INDUSTRY S. Chester Tube Co.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Missimer		14. MOTHER'S MAIDEN NAME Fannie Shepperd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, year, unknown) Yes W.W.L.		16. SOCIAL SECURITY NO 171-10-9197	
17. INFORMANT Mrs. Ruby P. Missimer, Wife. Cecilton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cor pulmonale DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Asthma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe brochial asthma of longstanding, severe emphysema, CVA, CHF.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 60 , to 4 April , 19 61 , that I last saw the deceased alive on Apr 4 , 19 61 , and that death occurred at 2:30 am from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 5 Apr 61			
ACTUAL SIGNATURE Wallace Obenshain		M.D. Cecilton, Md.	
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 8, 1961	
22c. NAME OF CEMETERY OR CREMATORY Lawncrest Cemetery		22d. LOCATION (City, town, or county) (State) Chester Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Yellow Millington		24a. REC'D BY REGISTRAR DATE APR 10 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



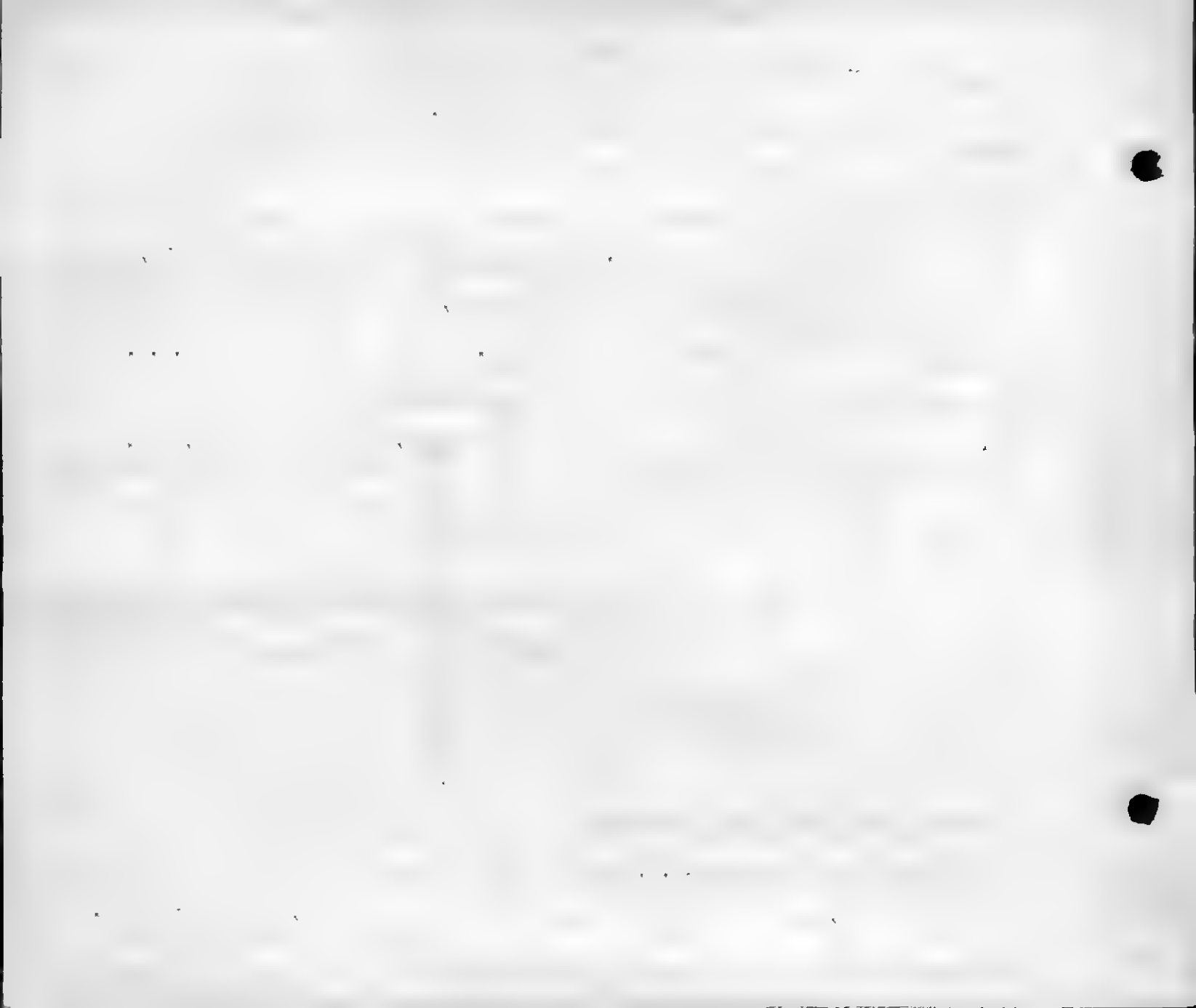
CERTIFICATE OF DEATH

Reg. Dist. No. 04191

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Annie E. Nickerson		4. DATE OF DEATH Month Day Year April 28, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1874
9. AGE (In years last birthday) yrs. 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Garey		14. MOTHER'S MAIDEN NAME Emma McGill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT George Humphrey,		Address Cecilton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 5 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1961, to 28 Apr 61, 1961, that I last saw the deceased alive on 28 Apr 61, 1961, and that death occurred at 7:00P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Obenshain M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1 May 61	
PHYSICIAN'S NAME (Type) Wallace Obenshain M.D.		Cecilton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May, 1, 1961	22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery	22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co; Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.		24a. REC'D BY REGISTRAR DATE MAY 3 '61	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

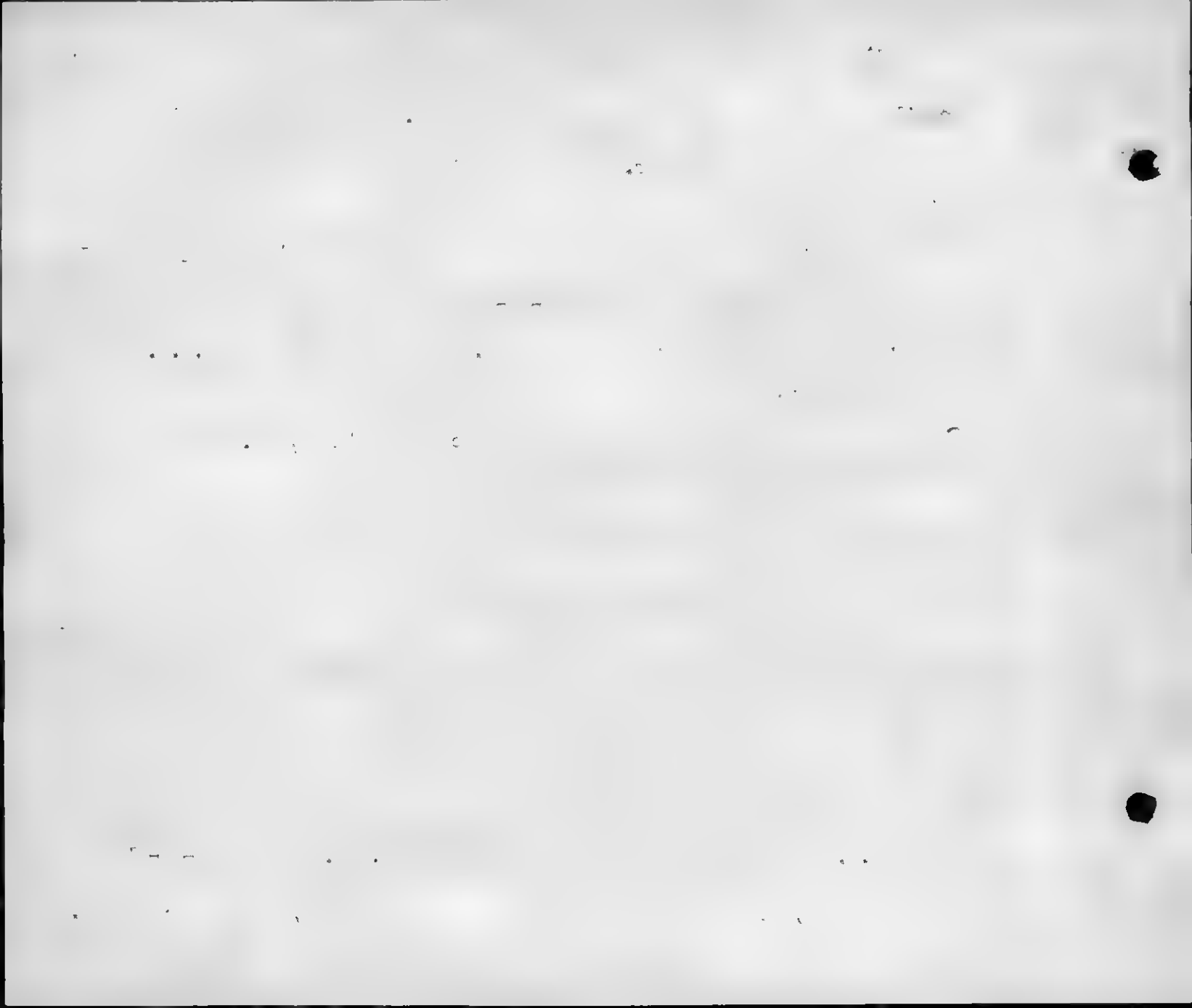
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4199

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04192

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>1 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cecilton</u> d. STREET ADDRESS <u>1</u>				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) <u>Jeremiah C Price</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>61</u>		5. SEX <u>M</u>					
6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-25-1897</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Care Taker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>On Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Ambrrose Price</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Drake</u>				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>221-16-7838</u>				17. INFORMANT <u>Jeremiah Price</u> Address <u>Cecilton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Massive Cerebral Hemorrhage</u> IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Severe Hypertension</u> Conditions, if any, which gave rise to immediate cause (b) <u>Severe Hypertension</u> (c) <u>Severe Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Severe Hypertension</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>R.C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>4-19-61</u>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>Rising Sun, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 22, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cecilton Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cecilton, Cecil Co; Md.</u>		22e. REC'D BY REGISTRAR <u>APR 24 '61</u>			
23. FUNERAL DIRECTOR <u>Edward Fellows</u>				23a. ADDRESS <u>Wellington, Md.</u>				23b. REGISTRAR'S SIGNATURE <u>Arthur S. Fenn</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04193

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.#3		c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.#3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Annie Reed		4. DATE OF DEATH		Month Day Year 4 22 19 61	
5. SEX F F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-2-1917		9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hosewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Reed		14. MOTHER'S MAIDEN NAME Silveragasta-?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Henry Dorsey R.D.#3 Elkton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER		DATE SIGNED 4-22-61	
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER Rising Sun, Md.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/61		22c. NAME OF CEMETERY OR CREMATORY Trinity Cem.	
22d. LOCATION (City, town, or country) (State) Zion Maryland		23. FUNERAL DIRECTOR John R. Bell		ADDRESS 909 Poplar St.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Knead		DATE APR 25 '61	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

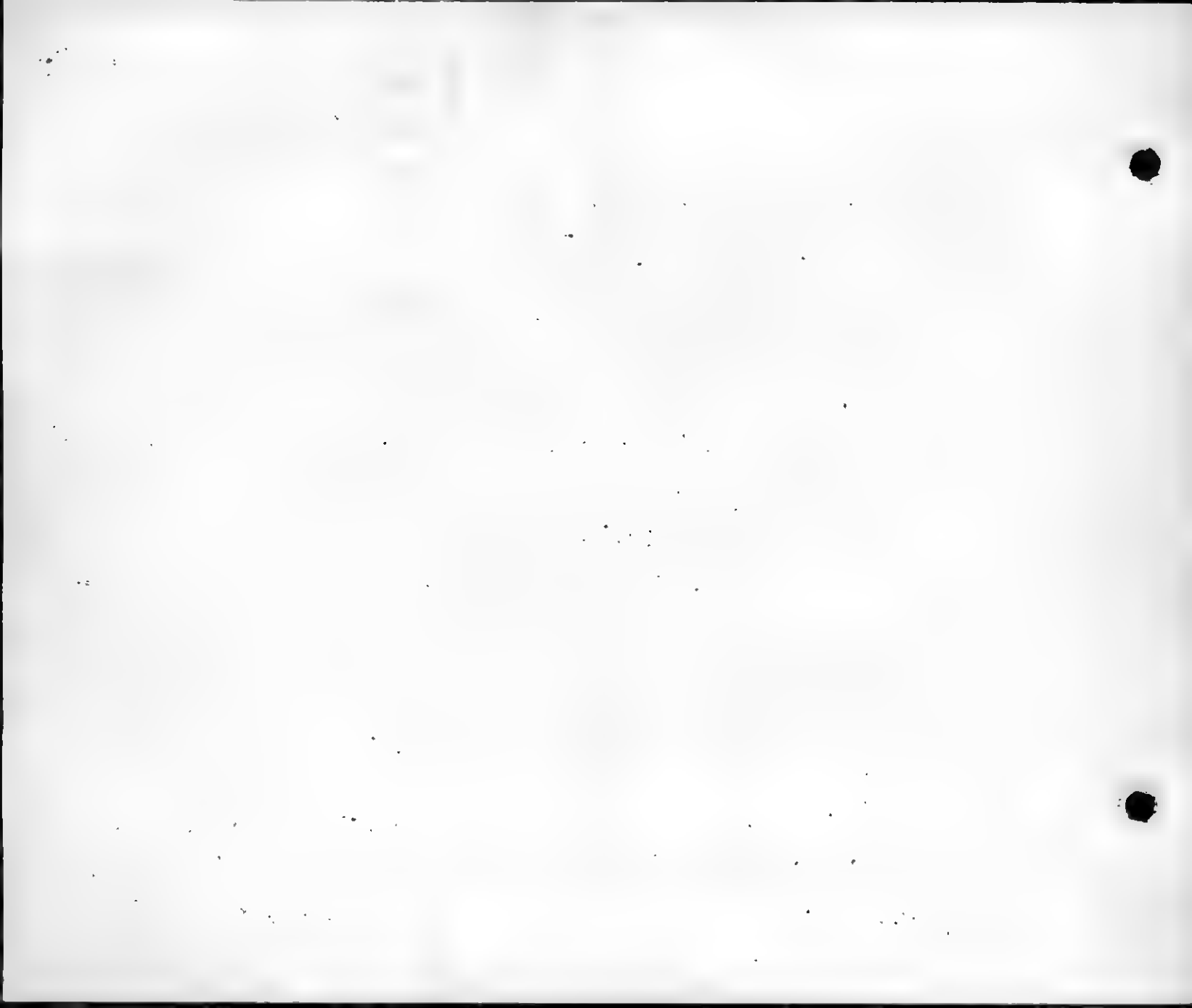
Reg. Dist. No. 04194

4201

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELIXTON</u> c. LENGTH OF STAY IN 1b <u>11 Days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDYTH</u> Middle <u>B.</u> Last <u>SCHAEFER</u>		4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1896</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKKEEPER</u>	11. BIRTHPLACE (State or foreign country) <u>SALEM, N. J.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM M. BROWN</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA F. AYERS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>218-18-7862</u>		17. INFORMANT <u>Mrs Mary E Cousins West Point, Md.</u> Address <u>West Point, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXEMIA</u> DUE TO <u>PERICARDITIS</u> DUE TO <u>CHOLECYSTITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>2 days</u> <u>3 days</u>
21. I certify that I attended the deceased from <u>April 1, 1961</u> to <u>April 16, 1961</u> , that I last saw the deceased alive on <u>April 10, 1961</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESAPEAKE CITY, CECIL, MD</u> DATE SIGNED <u>APR 19 1961</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <u>Henry J. Davis</u> M.D.		PHYSICIAN'S NAME (Type) <u>HENRY J. DAVIS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-18-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>	22d. LOCATION (City, town, or county) (State) <u>CHESAPEAKE CITY, CECIL, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> ADDRESS <u>Northeast Md</u>		24a. REC'D BY REGISTRAR <u>APR 19 1961</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. King</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

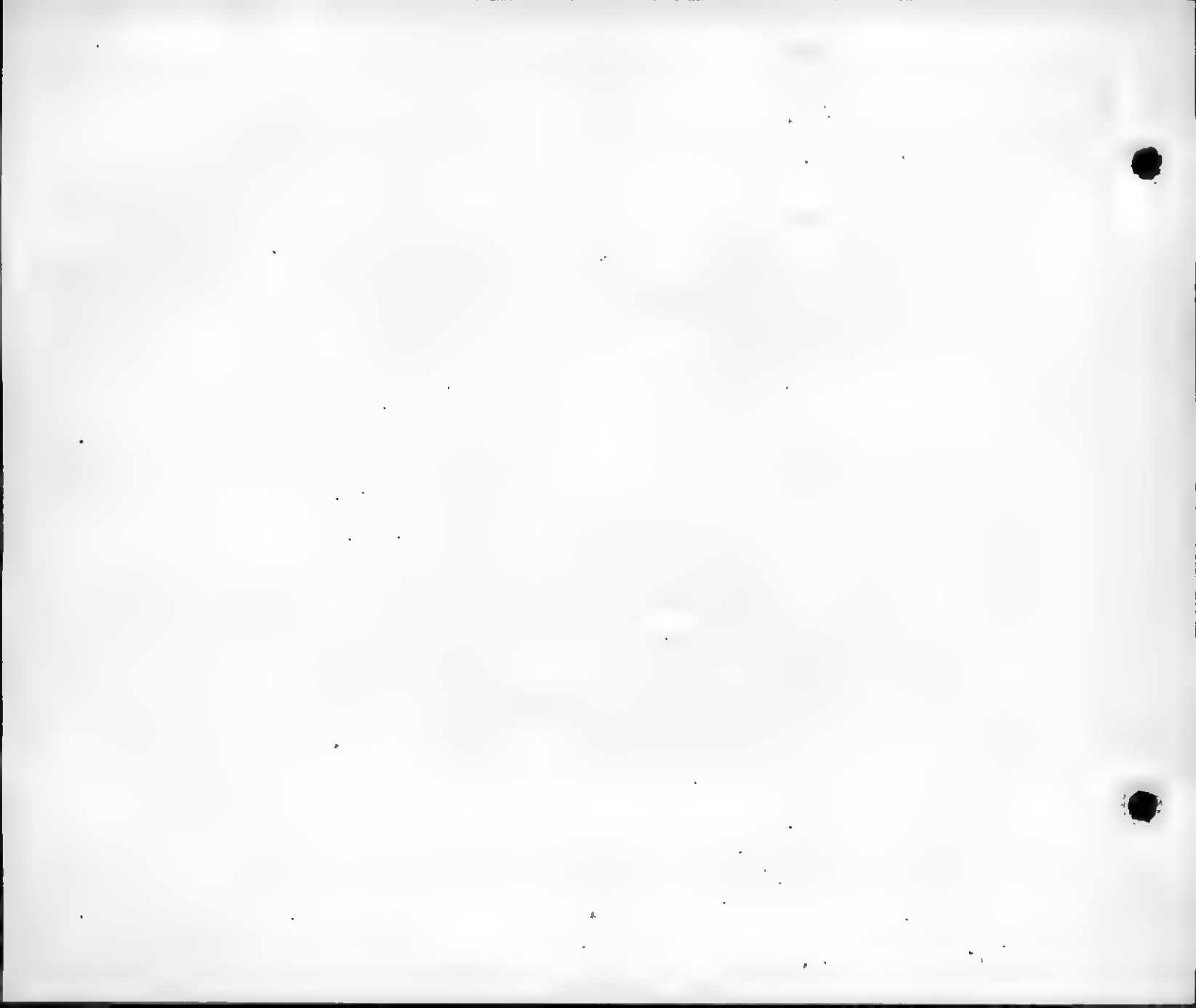
4202

CERTIFICATE OF DEATH

Reg. Dist. No. 04195

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY IN 1b 8 days		d. STREET ADDRESS 257 W High St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emma B. Short		4. DATE OF DEATH Month Day Year April 5 1961	
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/2/176
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Pratt		14. MOTHER'S MAIDEN NAME Armina Stoopes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO INFORMANT— Address Tillman E. Plummer Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure with uremia DUE TO (b) Arteriosclerosis, generalized, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ovarian cyst INTERVAL BETWEEN ONSET AND DEATH years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-28, 1961, to 4-5, 1961, that I last saw the deceased alive on 4-5, 1961, and that death occurred at 4:52 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Tillman E. Plummer M.D. 123 S. 14 Ave PHYSICIAN'S NAME (Type) Tillman D. Johnson Elkton Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 8, 1961	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		24a. REC'D BY REGISTRAR DATE APR 17 '61	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
4203
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04196

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> & <i>8</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>her own home</i>		e. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Charles</i> First <i>Edingleton</i> Middle <i>Harold</i> Last <i>1961</i>		4. DATE OF DEATH <i>April 19</i> Month <i>19</i> Day <i>1961</i> Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 11 1884</i>
9. AGE (In years last birthday) <i>77</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Harford Co. Md</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>James Edingleton</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Morris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>The</i>	
17. INFORMANT <i>Mrs Nelson Anderson</i> Address <i>Street</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <i>Chronic Myocarditis</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4-22-61</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan - 12 1961</i> to <i>April 18</i> , 1961, that (I) (we) last saw the deceased alive on <i>April 18</i> , 1961, and that death occurred at <i>7:18 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Clarence I. Benson</i> M.D.		22b. DATE SIGNED <i>4/19/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>CLARENCE I. BENSON</i>		22d. ADDRESS <i>PORT DEPOSIT, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>April 22, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Harbline M.</i>	23d. LOCATION (City, town, or county) (State) <i>Harford Co. Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey</i> ADDRESS <i>Wilmington</i>		25a. REC'D BY REGISTRAR <i>APR 26 '61</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

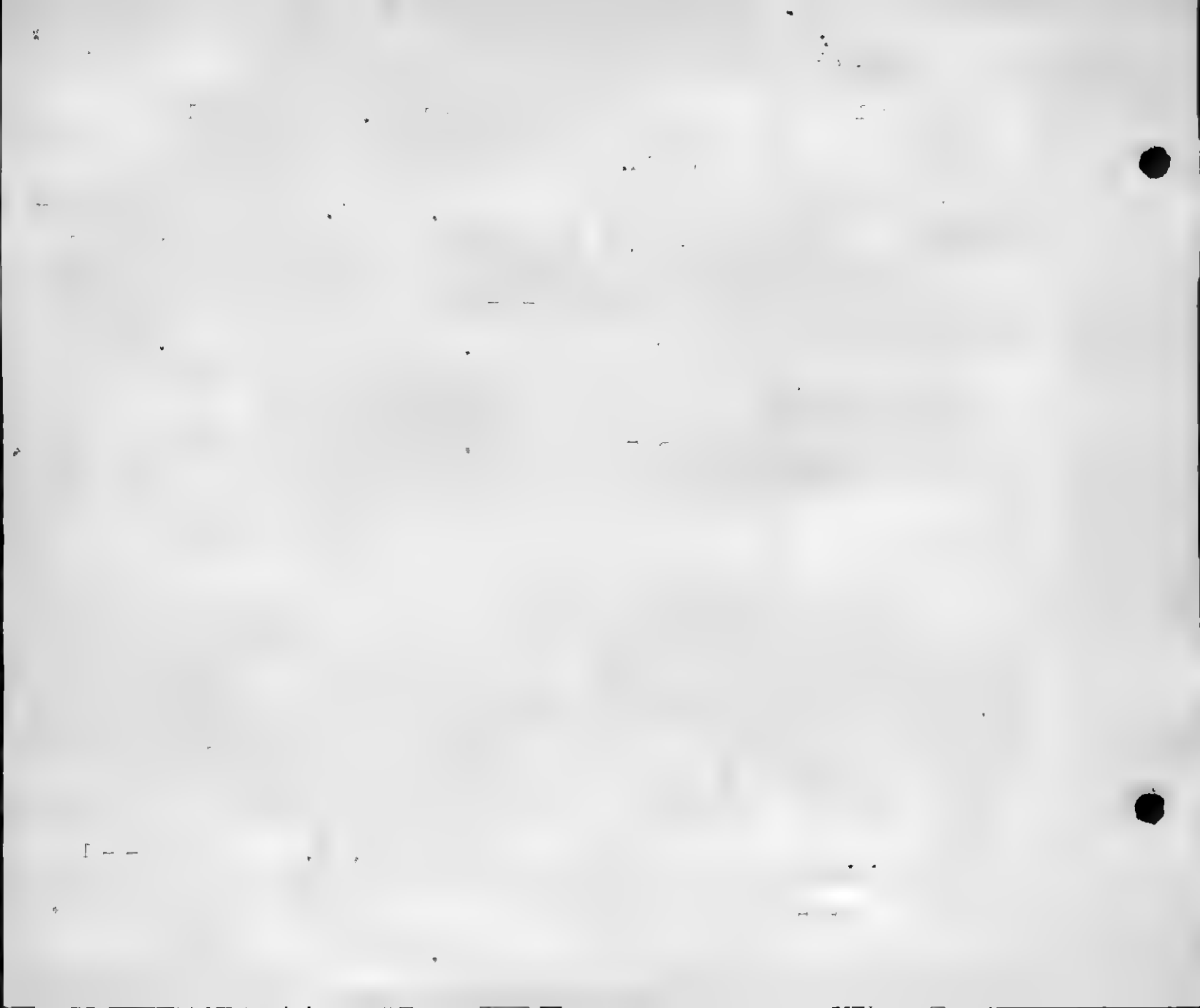
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4204

04197

1. PLACE OF DEATH a. COUNTY Cecil			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Cecil Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		
c. LENGTH OF STAY IN 1b 15 min.			d. STREET ADDRESS 389 W. Main St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Frank Victor Vandegrift			4. DATE OF DEATH Month 4 Day 3 Year 61		
5. SEX M			6. COLOR OR RACE W		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1-23-1909		
9. AGE (In years last birthday) 52 yrs.			10. IF UNDER 1 YEAR Months Days 19		
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver			12. IF UNDER 24 HRS. Hours Min. 19		
13. FATHER'S NAME Frank Vandegrift			14. BIRTHPLACE (State or foreign country) Md.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no			16. CITIZEN OF WHAT COUNTRY? U.S.A.		
17. SOCIAL SECURITY NO. 216-07-2658			18. MOTHER'S MAIDEN NAME Fannie Leiberman		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> SIGNATURE R.C. Dodson, M.D. EXAMINER'S NAME (Type) R.C. Dodson, M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-5-61 22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery 22d. LOCATION (City, town, or country) Elkton, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md. Address (Street, city, town, or county) DATE SIGNED 4-3-61		
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME, Donald M. Dee, Elkton, Md.			24a. REC'D BY REGISTRAR APR 5 '61 24b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Reg. Dist. No.

04198

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast		c. LENGTH OF STAY IN 1b 12 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 169 Cecil Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast	
3. NAME OF DECEASED (Type or print) Mrs Ursula M. Walters		4. DATE OF DEATH Month April Day 30 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1880
9. AGE (In years last birthday) yrs. 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Orleans Crossroads, W. Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John N. Ashkettle		14. MOTHER'S MAIDEN NAME Elizabeth Roby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Splenic Anemia (Banti's Disease) 78.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Hypertensive Cardiovascular Renal Disease Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 56 , to 30 April, 1961 , that I last saw the deceased alive on 29 April , 19 61 , and that death occurred at 11:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huebner M.D.		ADDRESS (Street, city or town, state) DATE SIGNED North East Md 30 April '61	
PHYSICIAN'S NAME (Type) Klaus H Huebner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/3/1961	22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	22d. LOCATION (City, town, or county) (State) Oxford, Chester Co. Penna.
23. FUNERAL DIRECTOR'S SIGNATURE William G. Johnston		24a. REC'D BY REGISTRAR MAY 3 '61	
ADDRESS Oxford Pa.		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4206

CERTIFICATE OF DEATH

Items 8 & 9, Film G-204 4/17/61 cac

04199

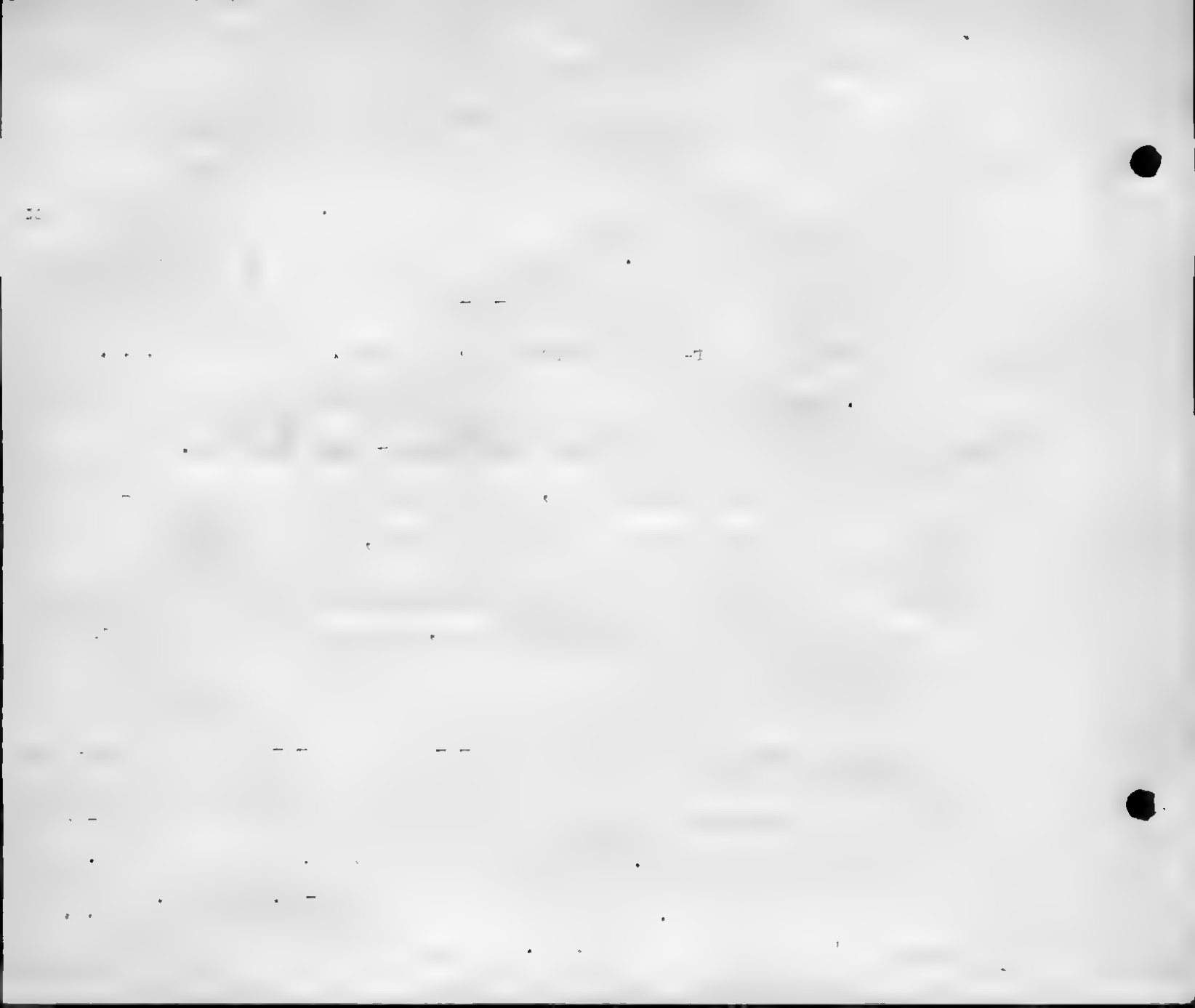
1. PLACE OF DEATH a. COUNTY Cecil			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 578 days			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5603 42nd Ave.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Albert C. Wangner			4. DATE OF DEATH Month Day Year April 5, 19 61			5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH 2-26-99/1897			9. AGE (In years last birthday) 64 1/2 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min. 1 9			11. BIRTHPLACE (County & State, or foreign country) Boston, Mass.			12. CITIZEN OF WHAT COUNTRY? U.S.A.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cylinder Pressman			10b. KIND OF BUSINESS OR INDUSTRY Printing Office			13. FATHER'S NAME Charles F. Wangner			14. MOTHER'S MAIDEN NAME Clara Hansom			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I							
16. SOCIAL SECURITY NO. 215 36 3788			17. INFORMANT VAH Records - Perry Point, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 4 1/2 (b) Arteriosclerotic heart disease, severe DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4-5 days			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis generalized, severe												20. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that VA Hospital attended the deceased from 9-5-59 to 4-5-61 , that (b) (we) last saw the deceased alive on 4-5-61 , and that death occurred at 5: a M, from the causes and on the date stated above.												22a. SIGNATURE A.L. Mooney		22b. DATE SIGNED 4-5-61		22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 4 5 61			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION (City, town or county) (State) Near-Mt. Rainer Md. Prince Georges County, M.D.			24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons, Hyattsville, Md.							
25a. REC'D BY REGISTRAR DATE 7 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Kline			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE			25e. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Francis Gasch's Sons



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04200

1. PLACE OF DEATH
a. COUNTY **CECIL** **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Bainbridge**
c. LENGTH OF STAY IN IL **4/12/61**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Bainbridge Training Center**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **MARYLAND** **CECIL**
b. COUNTY **CECIL**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Port Deposit**
d. STREET ADDRESS **88 South Main**

3. NAME OF DECEASED (Type or print) **CHARLES EDGAR WEBER**
4. DATE OF DEATH **APRIL 7 19 61**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **6/15/18**
9. AGE (in years last birthday) **42** yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired Navy** 10b. KIND OF BUSINESS OR INDUSTRY **Ohio** 11. BIRTHPLACE (State or foreign country) **USA**
12. CITIZEN OF WHAT COUNTRY **USA**

13. FATHER'S NAME **Unknown** 14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) **Yes** 16. SOCIAL SECURITY NO. **247145783** 17. INFORMANT **Mrs. Adele L. Weber, wife, Port Deposit, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Massive cerebral hemorrhage due to hypertension**
231X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Cirrhosis of the liver**

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Port Deposit** 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
SIGNATURE **R. C. Dodson** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **R. C. DODSON, M. D.** ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED **4/7/61**
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county) **Arlington, Virginia**

22a. BURIAL, CREMATION, REMOVAL (Specify) **4/11/61** 22b. DATE THEREOF **4/11/61** 22c. NAME OF CEMETERY OR CREMATORY **Arlington** 22d. LOCATION (City, town, or country) (State) **Arlington, Virginia**

23. FUNERAL DIRECTOR **Lee A. Patterson & Son** ADDRESS **PERRYVILLE, MD.** 24a. REC'D BY REGISTRAR **APR 10 '61** 24b. REGISTRAR'S SIGNATURE **Arthur L. Frank**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4208

CERTIFICATE OF DEATH

04201

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 1 mo. 12 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D. C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 216 F. Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES L. WILLIAMS		4. DATE OF DEATH Month Day Year April 28 19 61		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 9-10-96		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (County & State, or foreign country) Tennessee			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James William (deceased)		14. MOTHER'S MAIDEN NAME Betty Powell (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW-I		16. SOCIAL SECURITY NO. 241-18-1842		17. INFORMANT Address Hospital Records, V.A.H., Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lung, unresolved 18201 DUE TO (b) Bronchogenic carcinoma right upper lobe with Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. metastases to the ribs and liver DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that XXXXXX attended the deceased from <u>March 16, 1961</u> to <u>April 28, 1961</u> , and that death occurred at <u>7:30 a.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE A.L. Mooney		22b. DATE SIGNED 4-28-61		22c. PHYSICIAN'S NAME (Type) A.L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 5/2/61		23b. DATE THEREOF 5/2/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
23d. LOCATION (City, town or county) Baltimore, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR MAY 8 '61			
25b. REGISTRAR'S SIGNATURE Arthur J. Haines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. M

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04202											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point						c. LENGTH OF STAY IN 1b Less than 24hrs					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood 12X-2					
f. STREET ADDRESS						g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILEY H. WILSON						4. DATE OF DEATH Month April Day 3 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-96		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Haywood Wilson (deceased)						14. MOTHER'S MAIDEN NAME Sarah Carpenter (deceased)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I						16. SOCIAL SECURITY NO. 223-12-4306		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Bronchopneumonia, bilateral, unresolved. DUE TO (b) 2. Emphysema, bilateral, severe, both lungs. DUE TO (c) 3. Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-3-61 ACTUAL SIGNATURE R. C. DODSON M.D. EXAMINER'S NAME (Type) R. C. DODSON Address (Street, city, town, or county) Rising Sun, Md. (State)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 6, 1961		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or country) Abingdon, Harford, Md.,					
23. FUNERAL DIRECTOR'S NAME (Type) Howard K. McComas & Sons, Abingdon, Md.						24a. REC'D BY REGISTRAR DATE APR 5 '61		24b. REGISTRAR'S SIGNATURE Catharine S. Hume			

5

1. $\int_0^1 x^2 dx = \frac{1}{3}$

Subproject 4: V7.1 (2005/07)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4210

04203

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, 22 days c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) V.A. Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Delaware b. COUNTY <input checked="" type="checkbox"/> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wyoming 46X-23 d. STREET ADDRESS Wyoming Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM R. WILSON			4. DATE OF DEATH Month April Day 11 Year 1961				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-17		9. AGE (In years last birthday) 43 yrs. 10. KIND OF BUSINESS OR INDUSTRY Grocery		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (County & State, or foreign country) Viola, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Wilson			14. MOTHER'S MAIDEN NAME Orella Rantz				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 188-05-2566		17. INFORMANT Hospital records, VAH., Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock following operation, Excision of recurrent DUE TO (b) Brain tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Astro-Cytoma left hemisphere, Recurrent, Malignant PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 60 Hrs. Unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that XX (this hospital) attended the deceased from 3-20 , 1961, to 4-11 , 1961, and that death occurred at 7:45AM from the causes and on the date stated above.							
22a. SIGNATURE A. L. Mooney			22b. DATE SIGNED 4/11/61				
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D. Pathologist			22d. ADDRESS VAH., Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/14/61		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows			
24. FUNERAL DIRECTOR'S SIGNATURE William Esham Georgetown Del.		25a. REC'D BY REGISTRAR DATE APR 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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